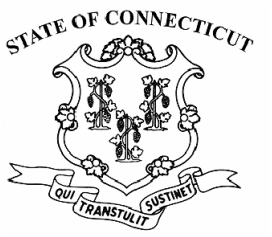

Senate

General Assembly

File No. 114

January Session, 2011

Substitute Senate Bill No. 18

Senate, March 21, 2011

The Committee on Insurance and Real Estate reported through SEN. CRISCO of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING APPEALS OF HEALTH INSURANCE BENEFITS DENIALS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subsection (a) of section 38a-226c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2011*):

(a) All utilization review companies shall meet the following minimum standards:

(1) Each utilization review company shall maintain and make available procedures for providing notification of its determinations regarding certification in accordance with the following:

(A) Notification of any prospective determination by the utilization review company shall be mailed or otherwise communicated to the provider of record or the enrollee or other appropriate individual within two business days of the receipt of all information necessary to

complete the review, provided any determination not to certify an admission, service, procedure or extension of stay shall be in writing. After a prospective determination that authorizes an admission, service, procedure or extension of stay has been communicated to the appropriate individual, based on accurate information from the provider, the utilization review company may not reverse such determination if such admission, service, procedure or extension of stay has taken place in reliance on such determination.

(B) Notification of a concurrent determination shall be mailed or otherwise communicated to the provider of record within two business days of receipt of all information necessary to complete the review or, provided all information necessary to perform the review has been received, prior to the end of the current certified period and provided any determination not to certify an admission, service, procedure or extension of stay shall be in writing.

(C) The utilization review company shall not make a determination not to certify based on incomplete information unless it has clearly indicated, in writing, to the provider of record or the enrollee all the information that is needed to make such determination.

(D) Notwithstanding subparagraphs (A) to (C), inclusive, of this subdivision, the utilization review company may give authorization orally, electronically or communicated other than in writing. If the determination is an approval for a request, the company shall provide a confirmation number corresponding to the authorization.

(E) Except as provided in subparagraph (F) of this subdivision with respect to a final notice, each notice of a determination not to certify an admission, service, procedure or extension of stay shall include in writing (i) the principal reasons for the determination, (ii) the procedures to initiate an appeal of the determination or the name and telephone number of the person to contact with regard to an appeal pursuant to the provisions of this section, and (iii) the procedure to appeal to the commissioner pursuant to section 38a-478n, as amended by this act.

(F) Each notice of a final determination not to certify an admission, service, procedure or extension of stay shall include in writing (i) the principal reasons for the determination, (ii) a statement that all internal appeal mechanisms have been exhausted, **[**and**]** (iii) a statement that the utilization review company shall provide to the enrollee, upon request, a copy of all enrollee-specific documents and information that were not provided by the provider of record or the enrollee and were considered in such final determination, and (iv) a copy of the application and procedures prescribed by the commissioner for filing an appeal to the commissioner pursuant to section 38a-478n.

(2) Each utilization review company shall maintain and make available a written description of the appeal procedure by which either **[**the enrollee or**]** the provider of record or the enrollee may seek review of determinations not to certify an admission, service, procedure or extension of stay. An appeal by the provider of record shall be deemed to be made on behalf of the enrollee and with the consent of such enrollee if the admission, service, procedure or extension of stay has not yet been provided or if such determination not to certify creates a financial liability to the enrollee. The procedures for appeals shall include the following:

(A) Each utilization review company shall notify in writing the **[**enrollee and**]** provider of record and the enrollee of its determination on the appeal as soon as practical, but in no case later than thirty days after receiving the required documentation on the appeal.

(B) On appeal, all determinations not to certify an admission, service, procedure or extension of stay shall be made by a licensed practitioner of the healing arts.

(3) With respect to a final determination not to certify an admission, service, procedure or extension of stay, each utilization review company shall, not later than five business days after receiving a request from the enrollee, provide to the provider of record and the enrollee by electronic mail, facsimile or other expeditious method all documents and information that were considered in making such final

determination.

[(3)**]** (4) The process established by each utilization review company may include a reasonable period within which an appeal must be filed to be considered.

[(4)**]** (5) Each utilization review company shall also provide for an expedited appeals process for emergency or life threatening situations. Each utilization review company shall complete the adjudication of such expedited appeals within two business days of the date the appeal is filed and all information necessary to complete the appeal is received by the utilization review company.

[(5)**]** (6) Each utilization review company shall utilize written clinical criteria and review procedures which are established and periodically evaluated and updated with appropriate involvement from practitioners.

[(6)**]** (7) Physicians, nurses and other licensed health professionals making utilization review decisions shall have current licenses from a state licensing agency in the United States or appropriate certification from a recognized accreditation agency in the United States, provided **[**,**]** any final determination not to certify an admission, service, procedure or extension of stay for an enrollee within this state, except for a claim brought pursuant to chapter 568, shall be made by a physician, nurse or other licensed health professional under the authority of a physician, nurse or other licensed health professional who has a current Connecticut license from the Department of Public Health.

[(7)**]** (8) In cases where an appeal to reverse a determination not to certify is unsuccessful, each utilization review company shall **[**assure**]** ensure that a practitioner in a specialty related to the condition is reasonably available to review the case. When the reason for the determination not to certify is based on medical necessity, including whether a treatment is experimental or investigational, each utilization review company shall have the case reviewed by a physician who is a

specialist in the field related to the condition that is the subject of the appeal. Any such review, except for a claim brought pursuant to chapter 568, that upholds a final determination not to certify in the case of an enrollee within this state shall be conducted by such practitioner or physician under the authority of a practitioner or physician who has a current Connecticut license from the Department of Public Health. The review shall be completed within thirty days of the request for review. The utilization review company shall be financially responsible for the review and shall maintain, for the commissioner's verification, documentation of the review, including the name of the reviewing physician.

[(8)**]** (9) Except as provided in subsection (e) of this section, each utilization review company shall make review staff available by toll-free telephone, at least forty hours per week during normal business hours.

[(9)**]** (10) Each utilization review company shall comply with all applicable federal and state laws to protect the confidentiality of individual medical records. Summary and aggregate data shall not be considered confidential if it does not provide sufficient information to allow identification of individual patients.

[(10)**]** (11) Each utilization review company shall allow a minimum of twenty-four hours following an emergency admission, service or procedure for an enrollee or his representative to notify the utilization review company and request certification or continuing treatment for that condition.

[(11)**]** (12) No utilization review company may give an employee any financial incentive based on the number of denials of certification such employee makes.

[(12)**]** (13) Each utilization review company shall annually file with the commissioner:

(A) The names of all managed care organizations, as defined in

section 38a-478, that the utilization review company services in Connecticut;

(B) Any utilization review services for which the utilization review company has contracted out for services and the name of such company providing the services;

(C) The number of utilization review determinations not to certify an admission, service, procedure or extension of stay and the outcome of such determination upon appeal within the utilization review company. Determinations related to mental or nervous conditions, as defined in section 38a-514, shall be reported separately from all other determinations reported under this subdivision; and

(D) The following information relative to requests for utilization review of mental health services for enrollees of fully insured health benefit plans or self-insured or self-funded employee health benefit plans, separately and by category: (i) The reason for the request, including, but not limited to, an inpatient admission, service, procedure or extension of inpatient stay or an outpatient treatment, (ii) the number of requests denied by type of request, and (iii) whether the request was denied or partially denied.

[(13)**]** (14) Any utilization review decision to initially deny services shall be made by a licensed health professional.

Sec. 2. Subsection (m) of section 38a-479aa of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2011*):

(m) Each utilization review determination made by or on behalf of a preferred provider network shall be made in accordance with sections 38a-226 to 38a-226d, inclusive, as amended by this act, except that any initial appeal of a determination not to certify an admission, service, procedure or extension of stay shall be conducted in accordance with subdivision **[**(7)**]** (8) of subsection (a) of section 38a-226c, as amended by this act, and any subsequent appeal shall be referred to the

managed care organization on whose behalf the preferred provider network provides services. The managed care organization shall conduct the subsequent appeal in accordance with said subdivision.

Sec. 3. Subdivision (12) of subsection (d) of section 38a-479bb of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2011*):

(12) A provision that the preferred provider network shall ensure that utilization review determinations are made in accordance with sections 38a-226 to 38a-226d, inclusive, as amended by this act, except that any initial appeal of a determination not to certify an admission, service, procedure or extension of stay shall be made in accordance with subdivision **[**(7)**]** (8) of subsection (a) of section 38a-226c, as amended by this act. In cases where an appeal to reverse a determination not to certify is unsuccessful, the preferred provider network shall refer the case to the managed care organization which shall conduct the subsequent appeal, if any, in accordance with said subdivision.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2011*	38a-226c(a)
Sec. 2	*October 1, 2011*	38a-479aa(m)
Sec. 3	*October 1, 2011*	38a-479bb(d)(12)

INS *Joint Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact: None

Municipal Impact: None

Explanation

There is no fiscal impact to the state or municipalities as this bill relates only to the notification requirements of private utilization review companies.

The Out Years

State Impact: None

Municipal Impact: None

OLR Bill Analysis

sSB 18

AN ACT CONCERNING APPEALS OF HEALTH INSURANCE BENEFITS DENIALS.

SUMMARY:

By law, a utilization review company must notify health benefit plan enrollees and health care providers of its final determination not to certify a hospital admission or extended stay, service, or procedure.

This bill requires the notice to include a statement that the company will give the enrollee, upon request, a copy of all the information and "enrollee-specific documents" (which the bill does not define) that were (1) not provided by the provider or enrollee and (2) considered in its final determination.

The bill also requires the company, within five business days of an enrollee's request, to provide the enrollee and provider with all documents and information considered in making its final determination. This information must be provided by email, fax, or other expeditious method.

EFFECTIVE DATE: October 1, 2011

BACKGROUND

Utilization Review Company

A utilization review company performs prospective and concurrent assessments of the necessity and appropriateness of health care services given to or proposed for a Connecticut resident.

Notification of Final Determinations

Current law requires a utilization review company's written notice

of its final determination not to certify a hospital admission or extended stay, service, or procedure to include (1) the principal reasons for the determination, (2) a statement that all internal appeal mechanisms have been exhausted, and (3) a copy of the application and procedures to file an external appeal to the insurance commissioner.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 13 Nay 7 (03/08/2011)